Psychiatric Services in General Hospitals

A Report of the Northern California Psychiatric Society's Committee On the Need for Psychiatric Services in General Hospitals

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• **A study made by a special committee appointed for the purpose by the Northern California Psychiatric Society found that a real need exists for local psychiatric services in general hospitals of the Northern California area. Such services can be provided readily—and in some communities are already available. A broad segment of the population looks to the general hospital to provide diagnosis and care and so enable the patient's prompt recovery from psychiatric disorders. The study further emphasizes the importance of such factors as a competent psychiatric chief, adequate staff and personnel and good planning in organizing inpatient and outpatient facilities and integrating treatment so that all the functions of the hospital are available to psychiatric patients. Granted these special considerations, the services can be provided more easily than many physicians, including some psychiatrists and administrators, suppose.**

THE Northern California Psychiatric Society in the fall of 1955 formed a committee* to study the need for psychiatric services in general hospitals. This is a brief report of the study, which showed that there exists a real need for psychiatric services in general hospitals, public and private, in the Northern California area. As a result of its study, the committee came to several conclusions: (1) Many people prefer to have psychiatric illnesses treated in the local communities; (2) this arrangement promotes prompt care and recovery; and (3) general hospitals can provide psychiatric care more easily than many physicians suppose.

Opinions on Needs

The committee began with Dr. Alfred Auerback's preliminary study of psychiatric needs in the Greater Bay Area, and then reviewed the extensive survey of the eleven western states by the Western Interstate Conference on Mental Health, the report of the 1951 Conference on Psychiatric Education, pertinent papers presented at the 1956 meeting of the American Psychiatric Association; several other national reports and a local survey of the San Francisco Mental Health Society. Committee members also consulted with various physicians, hospital administrators and psychiatrists in the Northern California area. The committee took note of the fact that representatives of the medical profession who appeared before a congressional committee studying the health of the nation emphasized the need for community psychiatric facilities. One of them, Dr. S. Bernard Wortis, of New York University School of Medicine, stressed the need for more community service clinics, guidance centers and general hospital psychiatric units as "the best method of preventing serious and chronic mental illness, with its associated drain, both economic and personal." The need for wider care, it was noted, led to passage in 1946 of the National Mental Health Act, which by 1951 had given aid to mental health programs in 51 states or jurisdictions.

Local Expression of Needs

A few examples from California Department of Mental Hygiene files indicate the extent and nature of the requests for help in dealing with local mental health problems.[4] One official asking for aid stated that the county had no psychiatric service, either inpatient or outpatient, and "no practicing psychiatrist or trained social worker." Another county declared that local psychiatric services are a "real community weapon against problems of narcotics, alcoholism, sex crimes, broken families and delinquency." A third county listed approximately a half dozen important psychiatric problems in children, adolescents and adults for which it had no treatment facilities. A Bay Area outpatient psychiatric clinic reported that since its opening in 1948 it had turned away ten persons for every patient it could treat. The Community Mental Health Services bill, originated by the California Medical Association, endorsed by more than 50 lay groups, and passed by the California State Legislature in 1957, is proof of wide community interest.

Finally, many patients and their families reported their surprise to find that hospitalization for an acute psychiatric illness is not locally available. Several careful studies showed the long delays and the vari-

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ous stopgaps, even the intervention of police, that may be tried before psychiatric care begins. These delays often mean that the patient must be deported to a distant, strange institution, a procedure with some stigma in the eyes of family, friends and employers. Valuable time has been lost in the legal commitment procedure, and after hospitalization more time has been lost in the interval between the new evaluation of the patient and the beginning of definitive treatment. Most of these delays and discontinuities in treatment could be avoided if adequate local facilities were available.

Psychiatric Units in General Hospitals

All physicians know the therapeutic advantages of continuity of medical care, wherein diagnosis, consultation, treatment and rehabilitation of an acute or exigent condition can proceed in a single setting without delay. Psychiatric disorders should have similar continuity of care. Phases of such disorder occur, from infancy to old age, both alone and associated with or secondary to such organic conditions as pregnancy, surgical treatment, fractures, brain tumors and all toxic states. Much of psychiatric, as of other medical care, is predictable and can be readily provided. Psychiatric emergencies also arise and require prompt treatment, quite as much as does severe hemorrhage.

Adequate psychiatric treatment for conditions occurring in patients already in hospital or dwelling in the community can be given in a general hospital psychiatric unit. An example is the management of the withdrawal symptoms after alcoholic intoxication. Medicine now accepts alcoholism at all stages as essentially a medical problem, but one in which nonmedical organizations can be of great aid. Acute alcoholic intoxication can be treated otherwise, but brief hospital care is best, in Block's opinion,[2] for laboratory procedures, intravenous therapy and emergency measures are readily available. The American Hospital Association years ago urged all general hospitals to set aside 5 per cent of beds for alcoholics. Yet Hayman's[5] recent survey of Southern California hospitals showed lack of beds and of psychiatrists for such care.

Short periods in the psychiatric unit also greatly benefit patients with psychosomatic conditions of the various body systems, brain disorders, mental deficiency, psychosis, neurosis and personality disorders. The great recent advances in therapy allow adequate treatment in the psychiatric unit of patients with geriatric disorders complicated by disturbance in their mental state.

Psychiatric units and outpatient clinics in general hospitals have also to some extent acted as way stations, permitting earlier release of state hospital patients and aiding them in their return to full economic and social status. A variation of this rehabilitative function has been successfully tried in several outstanding Canadian and United States psychiatric units that provide only day care[3] or night care.[6] This device allows each bed to be used by two patients in a 24-hour period. Such day or night services allow some patients to continue on the job or to remain in the community and near home at less than the usual expense.

Psychiatric outpatient services were not investigated in detail by the committee, since they may be established independently or in connection with other institutions than the general hospital. The committee found, however, that these services can be usefully integrated into the total outpatient services and clinics already established by any general hospital. The combined inpatient and outpatient psychiatric care offers the optimal service in keeping the patient within the community and hastening his participation in community life.

Matters of treatment, methods, training, staffing and administration, as well as medicolegal aspects and voluntary health insurance considerations are all discussed by Bennett and co-workers and special contributors in "The Practice of Psychiatry in General Hospitals."[1]

Installing and Maintaining a Psychiatric Unit

Installing and maintaining a psychiatric unit in a general hospital is easier than many physicians think. The committee found that all such units have prospered and that all are located in hospitals whose staffs have been able to see beyond prejudice and to respond to community needs by providing total care.

Understandably, prejudices and fears arise at the idea of admitting mental patients if they are regarded as "nuts and crazy people," if it is feared that the general hospital will become a "sobering-up tank." Many people still tend to regard psychosis as a dreadful combination of rage, fear and abnormal sexual drives, for which the individual should be locked up. Actually, very few patients lose control for more than brief moments, although they then require prompt, experienced treatment. Nearly anyone can recall from personal experience periods of struggle to maintain control, and therefore knows something of how it feels to be afraid and panicky. A psychosis may be much like this except for the degree of intensity and perhaps duration.

Psychiatric services can be provided in several ways—for example, a bed or two in the medical ward or a few private rooms made available for the purpose. Such flexible arrangements provide for care as the psychiatric needs arise. Other hospitals may wish to provide an area for psychiatry, as is the usual practice for the obstetrical or surgical or other departments. For purposes of economical operation the bed capacity of the psychiatric unit should be at least 15. This minimum number satisfactorily dis-

tributes the costs per patient for the area—both housekeeping costs and those for personnel. The physical plant, with suitable space and equipment on at least a 15-bed basis, can be provided at about the same costs as in other general hospital departments.

In whatever way the general hospital wishes to offer the psychiatric services, the emphasis should be on obtaining, first, the services of a competent, interested psychiatrist to head the department and give it mature direction and leadership. He would have the responsibility of integrating the unit into the general hospital so that total medical service for the patients could be provided. He must be able to work safely with all acute psychiatric conditions and emergencies; to deal with overanxious relatives; to exchange information and assistance with the referring physician; and to cooperate effectively with other departments and hospital administration. His direction is of course needed in guiding and teaching psychiatric staff personnel and in on-the-job training of other necessary personnel. Here the nursing staff is most important in providing the therapeutic milieu and the many services for patients. As a rule nurses must be recruited from other than state hospitals. The head nurse must be selected with as much care as is the psychiatrist. Student nurses are usually delightful additions to the staff, for they supply the fresh, eager interest that patients enjoy.

The ward layout is an architectural problem that should be planned with the psychiatrist and staff who are responsible for the treatment program. The idea, however, that adequately locked and screened wards obviate all dangers to the patient is wrong. The emphasis must be on the presence of a skilled staff, alert to the problems of caring for psychiatric patients. Locks on the doors and screens on the windows do not substitute for the understanding presence and care of the patient's needs; this is especially true during the time a patient has emergency needs.

The function of the psychiatric unit should be accurately described. It should not be represented to the public as a cure-all for major community problems, especially anti-social behavior. It is also important that the referring physician should as a rule consult with the psychiatrist before transferring a patient to the psychiatric service. The general hospital psychiatric unit cannot wholly replace the state hospital.

This short report cannot enter into discussions of financing, architecture or administration. Specific help in such matters can be obtained from the Northern California Psychiatric Society. Certain considerations affect the success of the unit and must be mentioned. For example, nurses should usually be paid $12 to $15 more a month than are those on general floors, to compensate them for greater specialization in nursing skills. The chief psychiatrist should be compensated appropriately for his skill and time if he is to give adequate direction and aid to patients, hospital and colleagues.

Psychiatric Advances in Treatment

That general hospital psychiatric units can operate successfully is owing in part to advances in psychiatric knowledge. Psychiatric therapy today is a dynamic speciality with much to offer to acutely ill patients. With the psychotherapeutic skills of a competent psychiatrist, and with the drugs and the physical adjuncts now available, most of the acute disturbances, however threatening the episode, respond to a course of treatment. Medical services that do not offer psychiatric care no longer meet the total community health needs and wishes. Indeed, the American Medical Association and the American Hospital Association have indicated that resident programs that do not include inpatient care of emotional disorders may soon be denied full credit and approval.

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